STATE OF CALIFORNIA

### HEALTH QUESTIONNAIRE (With Physician's Report)

STD. 610 (REV. 7-96) (Page 1 of 4)

# STATE LAW AND THE AMERICANS WITH DISABILITIES ACT REQUIRE APPLICANTS TO FILL IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM

| DATE JOB OFFER MADE |  |
|---------------------|--|
|                     |  |

| ONLY AFTER A JOB OFFER HAS BEEN MADE       |  |
|--|--|
| IN QUESTIONS ON PAGES 1 AND 2 OF THIS FORM | Statement below.)                                |
| WITH DISABILITIES ACT REQUIRE AFFEICANTS   | SOCIAL SECURITY NUIVIBER (Optional - See Privacy |

| PERMANENT TOPE PERMANENT TO BE COMPLETED BY THE APPLICANT DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLERANCE IS REQUIRED PRICE to Be splainted in the space provided on the back of this form.  If I MALE  DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLERANCE IS REQUIRED PRICE TO BE splainted in the space provided on the back of this form.  IF TAIT  MALE  TEMAL  72. Call bladder trouble  1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma 1. Residuals of policymelitis 1. Heaptitis, jaundice, or other liver aliments 4. Cancer, malignant tumor, or crysts 5. Dilabetics or sugar in urine 1. Alence of the nervous system 1. Any disorder of the nervous system 1. Any disorder of the nervous system 1. Residuals of the provision system 1. Cancer, malignant tumor, or crysts 1. Bear through the provision system 1. Any disorder of the nervous system 1. Residuals of the provision system s | THIS AREA TO BE COMPLETED BY HIRING AGENC               | Y - C    | OMPL   |                         |                              | D TO HIRING A        | GENC    | Υ   |  |  |
|--|---|----------|--------|-------------------------|------------------------------|----------------------|---------|-----|--|--|
| MRING MANAGESS NAME AND TELEPHONE NUMBER   DESIRED APPOINTMENT DATE   CENTRICATION NUMBER  | APPLICANT NAME (Last) (First)                           |          |        | (Middle)                | HIRING AGENCY NAME           |                      |         |     |  |  |
| Main      | ADDUCANT ADDDESS (Alumber and Street) (City)            | /Cto     | to)    | (7ID Codo)              | ACENCY ADDDESS               |                      |         |     |  |  |
| PREMINENT IPTE   PREMINENT   TAIL   T | APPLICANT ADDRESS (Number and Street) (City)            | (Sia     | ie)    | (ZIP Code)              | AGENCY ADDRESS               |                      |         |     |  |  |
| PREMINENT IPTE   PREMINENT   TAIL   T | CLASS TITLE AND POSITION NUMBER OF VACANCY              |          |        |                         | HIRING MANAGER'S NAME A      | AND TELEPHONE NUMBER | ?       |     |  |  |
| PERMANENT  |   |          |        |                         |                              |                      |         |     |  |  |
| ### THIS AREA TO BE COMPLETED BY THE APPLICANT  DO NOT LEAVE YOUR PRISENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNITIL YOU HAVE BEEN SPECIFICALLY NOTIFED TO REPORT FOR WORK. MEDICAL (LEARANGE IS RECUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE.)  Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.    Heart  | APPOINTMENT TYPE  |          |        | DESIRED APPOINTMENT     | DATE                         | CERTIFICATION NUMB   | ER      |     |  |  |
| THIS AREA TO BE COMPLETED BY THE APPLICANT  DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNTIL YOU HAVE BEEN SPECIFICALLY NOTIFIED TO REPORT FOR WORK. MEDICAL CLEARANCE IS REQUIRED PRIOR TO EMPLOYMENT IN STATE SERVICE. Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form.  BEEN DATE  | PERMANENT TAU LIMITED TERM                              | ı        |        |                         |                              |                      |         |     |  |  |
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| DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNITLY VOU HAVE BEEN SPECIFICALLY NOTHED TO REPORT FOR WORK MEDICIAL CLEARANCE IS REQUIRED PRIOR TO STATE SERVICE. Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form which is a provided on the back of this form.    FEMA   | REINSTATEMENT   | -        |        |                         |                              |                      |         |     |  |  |
| DO NOT LEAVE YOUR PRESENT EMPLOYMENT TO ACCEPT A POSITION IN STATE SERVICE UNITLY VOU HAVE BEEN SPECIFICALLY NOTHED TO REPORT FOR WORK MEDICIAL CLEARANCE IS REQUIRED PRIOR TO STATE SERVICE. Your answers to the following questions will be evaluated in conjunction with the essential functions of the desired position. In addition, a physical examination may be required. "YES" answers to questions 1 - 43 below must be explained in the space provided on the back of this form which is a provided on the back of this form.    FEMA   | THIS AREA TO  | ) BF (   | COME   | PLETED BY THE API       | PLICANT                      |                      |         |     |  |  |
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| examination may be required. "YES" answers to questions 1-43 below must be explained in the space provided on the back of this form.    FERMALE  | SPECIFICALLY NOTIFIED TO REPORT FOR WORK. ME            | DICAL    | CLEA   | RANCE IS REQUIRED       | PRIOR TO EMPLOYME            | nt in state servi    |         |     |  |  |
| remale   rem |   |          |        |                         |                              |                      |         | cal |  |  |
| or questions 1-31, have you ever had or do you have the follow- 19:  |   | MS 1 - 4 | 3 Deic | must be explained       |                              |                      | ioim.   |     |  |  |
| 1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma 2. Residuals of pollomyelitis 3. Hepatitis, jaundice, or other liver ailments 4. Cancer, malignant tumor, or cysts 5. Diabetes or sugar in urine 6. Pernicious anemia, leukemia, or other blood disorder or ailment 7. Mental illness or nervous breakdown 8. Any disorder of loss of consciousness 9. Seizure disorder or loss of consciousness 1. Heart trouble-including circulatory disease 2. Reheumatic fever 3. Any defect of bones or joints, including amputations, dislocations, or broken bones 5. Back pain or back injury 6. Head injury 7. Any problems with hips, knees, ankles, or feet 8. Any problems with hands, elbows, or shoulders 9. Seinting spells or dizziness 1. Heart in ouble-including circulatory disease 2. Sensitivity to dust or smoke 3. Any problems with hands, elbows, or shoulders 4. Have you ver baden to persone 4. Have you ver baden to persone 4. Alergies 4. Lave you blind in tooth eyes? 4. Any problems with hips, knees, ankles, or feet 4. Head injury 4. Are you taking any medication now or in the last 1. Heave you ever been hospitalized? If yes, list 1. Heave you ever been hospitalized? If yes, list 1. Heave you ever been hospitalized from work? 5. Benack pain or back in reasonand date of hospitalization? 5. Sensitivity to dust or smoke 5. Stomachor duodenal ulcer or other bowel problem  |   |          |        | FEMALE                  | neigni                       | WEIGHI               |         |     |  |  |
| I. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma   29. Shortness of breath   30. Any speechimpairment   31. History of addiction to drugs or alcohol   34. Have you ever worn contactlenses?   32. Do you wear or have you ever worn contactlenses?   33. Doyou or have you ever worn contactlenses?   34. Have you had any eye injury, surgery, or disease?   35. Are you blind in one eye?   36. Are you blind in not eye?   37. Do you wear an hearing alid or have you had at any eye injury, surgery, or disease?   38. Any disorder or loss of consciousness   39. Are you blind in both eyes?   39. Do you have any existing temporary medical conditions where the protection of    | For questions 1-31, have you ever had or do you have th | e follo  | DW-    |                         | ITEM                         |                      | YES     | NO  |  |  |
| 1. Lung or respiratory trouble, including bronchitis, tuberculosis, or asthma 2. Residuals of poliomyelitis 3. Hepatilis, jaundice, or other liver ailments 4. Cancer, malignant tumor, or cysts 5. Diabetes or sugar in urine 6. Pernicious anemia, leukemia, or other blood disorder or ailment 7. Mental illiness or nervous breakdown 8. Any disorder of the nervous system 9. Seizure disorder or loss of consciousness 1. Heart troubleincluding circulatory disease 2. Rheumatic fever 3. Any defect of bones or joints, including amputations, dislocations, or broken bones 4. Rheumatism, arithritis, or bursitis 5. Back pain or back injury 6. Head injury 7. Any problems with hips, knees, ankles, or feet 8. Any problems with hips, knees, ankles, or feet 9. Skin trouble 1. Allergies 2. Stomach or duodenalulcer or other bowel problem  2. Stomach or duodenalulcer or other bowel problem  2. Stomach or duodenalulcer or other bowel problem  3. Any other including broad disorder or all. History of addiction to drugs or alcohol 3. Any speech impairment 3. Any speech impairment 3. History of addiction to drugs or alcohol 3. History of addiction to druge or wor wor nor alcanes. 3. History of addiction to drugs or al   | ing:  |          |        | 27. Gall bladderti      | ddertrouble                  |                      | trouble |     |  |  |
| tuberculosis, or asthma  2. Residuals of pollomyelitis  3. Hepatitis, jaundice, or other liver ailments  4. Cancer, malignant tumor, or cysts  5. Diabetes or sugar in urine  6. Pernicious anemia, leukemia, or other blood disorder or ailment  7. Mental illiness or nervous breakdown  8. Any disorder of the nervous system  9. Seizure disorder or loss of consciousness  1. Heart troubleincluding circulatory disease  2. Rheumatic fever  3. Any defect of bones or joints, including amputations, dislocations, or broken bones  4. Rheumatism, arthritis, or bursitis  5. Back pain or back injury  6. Head injury  7. Any problems with hips, knees, ankles, or feet  8. Any problems with hands, elbows, or shoulders  9. Fainting spells or dizziness  1. Halergies  2. Sensitivity to dust or smoke  3. Any spoale the revous and octor's care for my conditions problem work?  4. Varicose veins  5. Does this illness or injury on the last injury or physical condition not mand adove (exclude)   | ITEM  | YES      | NO     | 28. Kidneyorblad        | bladder trouble              |                      |         |     |  |  |
| 2. Residuals of poliomyelitis 3. Hepatitis, jaundice, or other liver aliments 4. Cancer, malignant tumor, or cysts 5. Diabetes or sugar in urine 6. Pernicious anemia, leukemia, or other blood disorder or aliment 7. Mental illiness or nervous breakdown 8. Any disorder of the nervous system 9. Seizure disorder or loss of consciousness 0. Severe headaches or migraine 1. Heart troubleincluding circulatory disease 2. Rheumatism, arthritis, or bursitis 5. Back pain or back injury 6. Head injury 7. Any problems with hips, knees, ankles, or feet 8. Any problems with hands, elbows, or shoulders 9. Skin trouble 1. Allergies 2. Stomach or duodenalulicer or other bowel problem 4. Alave you beer of have you ever worn glasses? 32. Do you wear or have you ever worn glasses? 33. History of addiction to drugs or alcohol 32. Do you wear or have you ever worn glasses? 34. Have you had any eye injury, surgery, or disease? 35. Are you blind in both eyes? 36. Are you blind in both eyes? 37. Do you wear a hearing ald or have you had at any time a problem with your hearing? 38. Do you wear a hearing ald or have you had at any time a problem with your hearing? 39. Do you wear a hearing ald or have you had at any time a problem with your hearing? 39. Do you wear a hearing ald or have you had at any time a problem with your hearing? 39. Are you blind in both eyes? 31. Have you had problems with hips, the sesson and doctor's form any condition such as broken bones, eccovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2. 39. Are you at present under a doctor's care for any condition? Give reason and doctor's full name and address. 40. Are you taking any medication now or in the last 12 months? If yes, what? 41. Have you ever been hospitalized? If yes, list reason and date of hospitalization? 42. a. Have you had an illness or injury continue to limit your ability to perform certain types of work? 43. Have you ever had any other illness, injury or physical condition not named above (exclud   | 1. Lung or respiratory trouble, including bronchitis,   |          |        | 29. Shortness of breath |                              |                      |         |     |  |  |
| 3. Hepatitis, jaundice, or other liver ailments 4. Cancer, malignant tumor, or cysts 5. Diabetes or sugar in urine 6. Pernicious anemia, leukemia, or other blood disorder or ailment 7. Mental illness or nervous breakdown 8. Any disorder of the nervous system 9. Seizure disorder or loss of consciousness 10. Severe headaches or migraine 11. Heart troubleincluding circulatory disease 12. Rheumatic fever 13. Any defect of bones or joints, including amputations, dislocations, or broken bones 13. Back pain or back injury 14. Rheumatism, arthritis, or bursitis 15. Back pain or back injury 16. Head linjury 17. Any problems with hips, knees, ankles, or feet 18. Any problems with hands, elbows, or shoulders 19. Fainting spells or dizziness 10. Skin trouble 10. Skin trouble 11. Have you at present under a doctor's care for any condition? Givereason and doctor's full name and address. 18. Any problems with hands, elbows, or shoulders 19. Fainting spells or dizziness 10. Skin trouble 10. Skin trouble 11. Allergies 12. Bones this illness or injury which caused you to lose time from work? 15. Does this illness or injury continue to limit your ability to perform certain types of work? 19. June 1   |   |          |        | 30. Anyspeechir         | nyspeechimpairment           |                      |         |     |  |  |
| 4. Cancer, malignant tumor, or cysts 5. Diabetes or sugar in urine 6. Pernicious anemia, leukemia, or other blood disorder or ailment 7. Mental Illness or nervous breakdown 8. Any disorder of the nervous system 9. Seizure disorder or loss of consciousness 10. Severe headaches or migraine 11. Heart troubleincluding circulatory disease 12. Rheumatic fever 13. Any defect of bones or joints, including amputations, dislocations, or broken bones 13. Any problems with hips, knees, ankles, or feet 13. Any problems with hips, knees, ankles, or feet 13. Any problems with hips, knees, ankles, or feet 13. Any problems with hips, conditions 13. Any problems with hips, shoes, ankles, or feet 13. Any problems with hips, conditions 14. Have you ver been hospitalized? If yes, list reason and date of hospitalization? 15. Sensitivity to dust or smoke 16. Pernicious anemia, leukemia, or other bowel problem 17. Any problems or joints, including amputations address. 18. Doyou wear a hearing aid or have you had at any time a problem with your hearing? 19. Source a hearing aid or have you had at any time a problem with your hearing? 19. Source a hearing aid or have you had at any time a problem with your hearing? 19. Source a hearing aid or have you had at any time a problem with your hearing? 20. Source a hearing aid or have you had at any time a problem with your hearing? 21. Are you blind in one eye? 22. Are you blind in one eye? 23. Are you blind in one eye? 23. Are you blind in one your have you were nate in particulation and any other illness. In particulation and any other illness, in particulation and anticipated date of recovery one page 2. 23. Are you at present under a doctor's care for any condition? Givereason and doctor's full name and address. 24. Are you taking any medication now or in the last 12 months? If yes, what? 25. Any problems with hips, knees, ankles, or feet 26. Are you taking any medication now or in the last 12 months? If yes, what? 27. A Have you ever been hospitalized? If yes, list reason and date of h   | 2. Residuals of poliomyelitis                           |          |        | 31. History of add      | ddiction to drugs or alcohol |                      |         |     |  |  |
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| or allment  34. Have you had any eye injury, surgery, or disease?  35. Are you blind in one eye?  36. Are you blind in one eye?  37. Do you wear a hearing aid or have you had at any time a problem with your hearing?  38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.  38. Any defect of bones or joints, including amputations, dislocations, or broken bones  48. Rheumatism, arthritis, or bursitis  59. Back pain or back injury  40. Are you taking any medication now or in the last 12 months? If yes, what?  41. Have you ever been hospitalized? If yes, list reason and date of hospitalization?  42. a. Have you ever been from work?  43. Have you ever had any other illness, injury or physical condition not named above (exclude)   | · · ·   |          |        |                         |                              |                      |         |     |  |  |
| or ailment  7. Mental illness or nervous breakdown  8. Any disorder of the nervous system  9. Seizure disorder or loss of consciousness  1. Beart troubleincluding circulatory disease  2. Rheumatic fever  3. Any defect of bones or joints, including amputations, dislocations, or broken bones  5. Back pain or back injury  7. Any problems with hips, knees, ankles, or feet  8. Any problems with hands, elbows, or shoulders  9. Fainting spells or dizziness  1. Heart troubleincluding circulatory disease  2. Sensitivity to dust or smoke  3. Are you blind in one eye?  3. Are you blind in both eyes?  3. Any goubland in both eyes?  3. Are you blind in both eyes?  3. Any goubland in both eyes?  3. Do you wear a hearing aid or have you had an yith earing?  condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.  3. Are you at present under a doctor's care for any condition? Givereason and doctor's full name and address.  4. Are you taking any medication now or in the last 12 months? If yes, what?  4. Are you taking any medication now or in the last 12 months? If yes, what?  4. Have you ever been hospitalized? If yes, list reason and date of hospitalization?  4. Have you ever been hospitalization?  4. Have you had an illness or injury which caused you to lose time from work?  b. Does this illness or injury continue to limit your ability to perform certain types of work?  4. Varicose veins  5. Stomach or duodenal ulcer or other bowel problem   | <u> </u>  |          |        | •                       |                              |                      |         |     |  |  |
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| 0. Severe headaches or migraine       38. Do you have any existing temporary medical condition such as broken bones, recovery from surgery, pregnancy, etc.? If yes, list condition and anticipated date of recovery on Page 2.         2. Rheumatic fever       39. Are you at present under a doctor's care for any condition? Givereason and doctor's full name and address.         4. Rheumatism, arthritis, or bursitis       40. Are you taking any medication now or in the last 12 months? If yes, what?         5. Back pain or back injury       40. Are you taking any medication now or in the last 12 months? If yes, what?         8. Any problems with hips, knees, ankles, or feet       41. Have you ever been hospitalized? If yes, list reason and date of hospitalization?         9. Skin trouble       42. a. Have you had an illness or injury which caused you to lose time from work?         1. Allergies       b. Does this illness or injury continue to limit your ability to perform certain types of work?         4. Varicose veins       43. Have you ever had any other illness, injury or physical condition not named above (exclude  | ·   |          |        | <del>-</del>            |                              |                      |         |     |  |  |
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| 3. Any defect of bones or joints, including amputations, dislocations, or broken bones 4. Rheumatism, arthritis, or bursitis 5. Back pain or back injury 6. Head injury 7. Any problems with hips, knees, ankles, or feet 8. Any problems with hands, elbows, or shoulders 9. Fainting spells or dizziness 1. Allergies 2. Sensitivity to dust or smoke 3. High or low blood pressure 4. Varicose veins 5. Stomach or duodenal ulcer or other bowel problem  anticipated date of recovery on Page 2.  39. Are you at present under a doctor's care for any condition? Givereason and doctor's full name and address.  40. Are you taking any medication now or in the last 12 months? If yes, what?  41. Have you ever been hospitalized? If yes, list reason and date of hospitalization?  42. a. Have you had an illness or injury which caused you to lose time from work?  b. Does this illness or injury continue to limit your ability to perform certain types of work?  43. Have you ever had any other illness, injury or physical condition not named above (exclude   | j   |          |        | 1 /                     |                              | •                    |         |     |  |  |
| tions, dislocations, or broken bones  4. Rheumatism, arthritis, or bursitis  5. Back pain or back injury  6. Head injury  7. Any problems with hips, knees, ankles, or feet  8. Any problems with hands, elbows, or shoulders  9. Fainting spells or dizziness  10. Skin trouble  11. Allergies  12. Allergies  13. Have you ever been hospitalized? If yes, list reason and date of hospitalization?  13. Have you had an illness or injury which caused you to lose time from work?  13. Does this illness or injury continue to limit your ability to perform certain types of work?  14. Have you ever had any other illness, injury or physical condition not named above (exclude)   |   |          |        |                         |                              |                      |         |     |  |  |
| <ul> <li>4. Rheumatism, arthritis, or bursitis</li> <li>5. Back pain or back injury</li> <li>6. Head injury</li> <li>7. Any problems with hips, knees, ankles, or feet</li> <li>8. Any problems with hands, elbows, or shoulders</li> <li>9. Fainting spells or dizziness</li> <li>10. Skin trouble</li> <li>11. Allergies</li> <li>12. Sensitivity to dust or smoke</li> <li>13. High or low blood pressure</li> <li>14. Have you ever been hospitalized? If yes, list reason and date of hospitalization?</li> <li>15. Stomachorduodenalulceror other bowel problem</li> <li>16. Have you taking any medication now or in the last reason and date of hospitalized? If yes, list reason and date of hospitalized?</li> </ul>   | ,   |          | /      |                         |                              | <u> </u>             |         |     |  |  |
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|  | 24. Varicose veins                                      |          |        |                         |                              |                      |         |     |  |  |
| 6. Rupture or hernia minor problems such as colds, flu, etc.)?   | 25. Stomach or duodenal ulcer or other bowel problem    |          |        |                         |                              |                      |         |     |  |  |
|  | 26. Rupture or hernia                                   |          |        | minor proble            | ms such as colds, flu, e     | etc.)?               |         |     |  |  |

(Continue on reverse.)

#### PRIVACY NOTICE

Official Responsible: Medical Officer, State Personnel Board, P.O. Box 944201, Sacramento, CA 94244-2010; Authority: Government Code Section 18931; Purpose: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; Providing Information: Medical clearance is required prior to employment in State service; Effects of Not Providing Information: Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous; Access: Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

### **HEALTH QUESTIONNAIRE** (With Physician's Report) STD. 610 (REV. 7-96) (Page 2 of 4)

| DATE<br>to pe<br>this c<br>direc | OF ONSE<br>rform satis<br>ompleted<br>tly to the | T, YOUR PRESENT CONDITION AS YOU<br>of actorily the duties of the position for<br>I form to the hiring agency unless (1) | ation of all items to which you have answered "YE EVALUATE IT and what accommodations to you which you are applying without endangering the advised otherwise by the hiring agency, or (2) for ard, P. O. Box 944201, Sacramento, CA 94244-201 | r limitations, if any, y<br>health and safety o<br>strong personal rea | you feel you may require<br>if yourself or others. <b>Return</b><br>isons you prefer to send it |
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STATE OF CALIFORNIA

#### **HEALTH QUESTIONNAIRE** (With Physician's Report)

STD. 610 (REV. 7-96) (Page 3 of 4)

(To be completed by a licensed physician and surgeon only after a job offer has been made)

TO THE PHYSICIAN: The attached Health Questionnaire must be completed and submitted to you by the person whose name appears below. It is intended to assist you in conduct of the examination. You are requested to complete the medical examination report. The Hiring Agency is responsible for payment of

number-Required)

the fee. See page 4 for instructions. APPLICANT'S SOCIAL SECURITY NUMBER (Optional) ALL ITEMS BELOW ARE MANDATORY--COMPLETED REPORT SHOULD BE RETURNED TO HIRING AGENCY APPLICANT'S NAME (Last) (First) (Middle) HIRING AGENCY NAME APPLICANT'S ADDRESS (Number and Street) (State) (ZIP Code) AGENCY ADDRESS (City) CLASS TITLE AND POSITION NUMBER OF VACANCY HIRING MANAGER'S NAME AND TELEPHONE NUMBER APPOINTMENT TYPE CERTIFICATION NUMBER DESIRED APPOINTMENT DATE PERMANENT LIMITED TERM PEACE OFFICER CURRENT OCCUPATION (If reinstatement, enter dates of previous State employment) REINSTATEMENT DOCTOR: Write comments on any positive or negative findings for evaluation of applicant. (If more space is needed, use reverse of this form and/or a separate sheet of paper.) Examine color vision only when required in Minimum Qualifications. 1. HEIGHT VISION 2A. COLOR VISION TESTING REQUIRED CONTACT YES GLASSES NORMAL ISHIHARA ABNORMAL NO LENSES WEIGHT (Without 3. HEARING (Ordinary conversation heavyclothingor UNCORRECTED CORRECTED AUDIOMETRY (If done) at 15 feet considered normal) NEAR DISTANT NEAR DISTANT LEFT RIGHT 500 1000 2000 3000 4000 Right 20/ Right / 15 Left 20/ / 15 HEARING AID USED YES NO Both 20/ Left 5.(A) RESTING PULSE RATE 5.(B) BLOOD PRESSURE 4. HEAD (Eyes, ears, nose, mouth, throat) 6. LUNGS (Breath sounds, rales) 7. HEART (enlargement, rhythm, sounds) AND CIRCULATORY SYSTEM 8. NERVOUS SYSTEM (Reflexes, motor strength, atrophy, sensory changes, or any abnormal reflexes) 9. ABDOMEN (G.I. system, liver, spleen, masses, scars, herniae, etc.) HERNIA 10. GENITOURINARY SYSTEM INCLUDING KIDNEYS 11. RECTAL Fistual Hemorrhoids 12. SPINE (Deformity, tenderness, range of motion) 13. EXTREMITIES (Strength, range of motion, deformities, atrophy or sensory changes 14. SKIN AND LYMPHATICS, SIGNIFICANT SCARRING 15. VARICOSE VEINS (Severity) 17. ANY WORK LIMITATION (Specify) 16, URINALYSIS Specific Gravity Albumin Sugar 18. PSYCHIATRIC EVALUATION (Any mental disorder observed) 19. PHYSICIAN'S SIGNATURE (Required) PHYSICIAN' S NAME AND ADDRESS - (Required - Please print) (Required) DATE SIGNED PHYSICIAN'S TAXPAYER I.D. NUMBER (FEIN or SSA

## HEALTH QUESTIONNAIRE (With Physician's Report) SID. 610 (REV. 7-96) (Page 4 of 4)

#### NOTICE TO PHYSICIANS AND CLINICS

The State of California requires preplacement physical examinations for certain classes of employment. The State also has many employees who are required to have a physical examination at the time of renewal of their Class I or II driver's license, when the possession of the license is required for the position.

If the hiring agency is not identified, do not perform the examination. The State Personnel Board does not have the authority to pay for examinations.

#### **REPORTS**

The medical report should be sent to the Hiring Agency shown on Page 1, unless you are requested by the person examined to mail this medical report directly to the State Personnel Board Medical Office, P. O. Box 944201, Sacramento, California 94244-2010.

#### **BILLINGS**

Please send your bill for this examination to the Hiring Agency as indicated on Page 1. Include your Federal Employer Identification Number or Social Security Number for tax reporting purposes.

The State Hiring Agency will pay the fee for this Medical Examination Report up to a maximum determined by the Department of Health Services and set forth in the State Administrative Manual (Section 0190.1). The current fee allowance may be obtained from the Hiring Agency shown on Page 1. If there should be additional studies or examinations required for more complete evaluation of the individual, these examinations will be at the expense of the applicant.